ID # _____

ADVANCED FOOT CARE

TO OUR NEW PATIENTS:

I would personally like to thank you for choosing Advanced Foot Care. We are located at 1635 N. Lee Trevino, Ste. C El Paso, TX 79936. After more than 25 years of being in practice here in El Paso, I find that one of the most challenging things today, are insurance companies. The insurance companies in today's world have different processes as to what needs to be authorized and verified and that is one of the most common delays that we have in our office.

In order to assist us in seeing you in a timely manner prior to your appointment, please fill out the following patient packet. Please bring this packet with you at the time of your appointment along with an identification card, your insurance card, and all medications that you take. You may bring a list of medications including the name, dosage, frequency, and the reason you take the medication.

Some insurance policies may require a referral from your primary care physician or an authorization in order for you to be seen. It is your responsibility to provide this information to our office. *If you are not able to provide this information <u>your insurance</u> unfortunately will not allow our office to be able to see you until the correct referrals and authorizations are provided.*

Please be sure to bring along with you on the day of your appointment any recent x-rays, tests, scans, reports, or any other pertinent information or items that may assist us in your treatment. Please complete and sign all forms, including the HIPPA form, as this is a federal requirement to protect you for all disclosure of your health information.

Thank you for choosing Advanced Foot Care and we welcome you to our facility.

Dr. Gabriel Lazar

ID # _____

Email Address:_____Today's Date: _____

Patient's Name: _____ D.O.B.: _____/_____/_____

Age: _____yrs Gender: [_] Male [_] Female **Social Security #: _____-_____-_____**

Marital Status: [_] Married [_] Single [_] Divorced [_] Other

Address: _____ P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Home #: (____) _____-_____ Cell #: (____) _____-_____ Work #: (____) _____-_____

Employer: _____ Occupation: _____

RESPONSIBLE PARTY: [_] Same as Above

Name: _____ D.O.B.: _____/_____/_____

Gender: [_] Male [_] Female **Social Security #: _____-_____-_____**

Relation to patient: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

Home #: (____) _____-_____ Cell #: (____) _____-_____ Work #: (____) _____-_____

Employer: _____ Occupation: _____

How were you referred to our office?
[_] Friend/Family [_] Insurance [_] Website [_] Phonebook [_] Physician: Dr._____ [_] Other: _____

EMERGENCY CONTACT / RELEASE INFORMATION
Name: _____ Relationship: _____ Phone #: (___) _____-_____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance Name: _____
[_] Same as patient [_] Responsible party [_] Other: _____
Policy Holder's Name: _____ D.O.B.: ____/____/_____ S.S.#: _____-_____-_____
Policy #: _____ Group #: _____ Relation to patient: _____
Employer: _____ Occupation: _____

SECONDARY INSURANCE
Insurance Name: _____
[_] Same as patient [_] Responsible party [_] Other: _____
Policy Holder's Name: _____ D.O.B.: ____/____/_____ S.S.#: _____-_____-_____
Policy #: _____ Group #: _____ Relation to patient: _____
Employer: _____ Occupation: _____

ID # _____

Advanced Foot Care

Dr. Gabriel Lazar, DPM

HIPPA FORM

I _____ understand that as a part of my healthcare, Advanced Foot Care originates and maintains paper and/or electronic records describing my healthcare history, symptoms, test results, examinations, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *Basis for planning my care and treatment.*
- *Means of communication among the many healthcare professionals who contribute to my care.*
- *Source of information for applying my diagnosis and surgical information to my bill.*
- *Means by which a third party payer can verify that services billed were actually provided.*
- *Tools for routine healthcare operations such as: Assessing quality and reviewing the competence of healthcare professionals.*

I understand and have received a notice of information practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- *The right to review the notice prior to signing this consent.*
- *The right to object to the use of my health information directory purposes.*
- *The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.*

I understand that Advanced Foot Care is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance there on.

I also understand that by refusing to sign this consent or revoking this consent this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I further understand that Advanced Foot Care reserves the right to change their notice and practices and prior to implementation in accordance with section 164.520 of the code of federal regulations. Should Advanced Foot Care change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:
_____.

I understand that as part of this organizations treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and / or e-mail.

I fully understand and accept the terms of this consent.

_____ _____/_____/_____

Patient's Signature Date

Received By: _____ on _____/_____/_____

ID # _____

Advanced Foot Care

Dr. Gabriel Lazar, DPM

Patient(s) Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or manager.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment at Advanced Foot Care.
- Unless other arrangements have been made in advanced by you, or your health insurance carrier, payments for services are due at the time of visit. We will accept ***VISA, Master Card, Cash, or Check***.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to Dr. Gabriel Lazar. In other words, you agree to have your insurance company pay Dr. Gabriel Lazar directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care/treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "***NOT COVERED***", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized service or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any *charges denied*.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advanced if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due in the office.
- There is a service fee of **$25.00** for **all returned checks**. Your insurance company does **NOT** cover this fee.
- There is a service fee of **$25.00** if you **fail to cancel your appointment** without providing a **24 hour** notice. Your insurance company does **NOT** cover this fee.
- There is a service fee of **$25.00** for any disability forms that need to be filled. Your insurance company does **NOT** cover this fee.

_____ _____/_____/_____

Patient's Signature/Responsible Party Date

_____ _____/_____/_____

Printed Name of Patient/Responsible Party Date

ID # _____

Advanced Foot Care

Dr. Gabriel Lazar, DPM

Consent for Treatment

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I, the patient identified below or the patient's authorized representative, consent to the procedures which may be performed during any visit to Advanced Foot Care which may include, but are not limited to, laboratory procedures, including testing of blood or other bodily fluid to determine the presence of any communicable disease such as, to the extent allowed by law, Hepatitis and Human Immunodeficiency Virus (the causative agent of AIDS), x-ray examination, medical and surgical treatment or procedures, such as but not limited to injections, ulcer debridement, callus debridement, I&D, etc., or anesthesia rendered for the patient under the general and special instructions of my doctor and staff.

2. CONSENT TO PHOTOGRAPH

I permit Advanced Foot Care to photograph as a part of the documentation of my/the patient's medical/surgical condition. These photographs will be maintained as part of my/the patient's permanent medical record. I understand and acknowledge that Advanced Foot Care is permitted to use cameras to monitor all patients.

The undersigned certifies that I have read the foregoing, received a copy thereof, and I am the patient, the patient's representative, or I am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____/_____/_____

Patient / Patient's Authorized Signature Date

_____ _____/_____/_____

If other than patient, indicate relationship Date

_____ _____/_____/_____

Witness Date

ID # _____

DATE: ____/_____/____

Patient's Name: _____ D.O.B.: ____/____/_____

Did your problem begin following:

[_] Work Injury [_] Motor Vehicle Accident [_] Daily Regimen [_] Nothing [_] Diabetic Foot Exam

Reason for visit: _____

_____

Type of pain or sensation:

[_] Constant [_] Occasional [_] Dull [_] Aching [_] Stabbing [_] Throbbing [_] Sharp [_] Numbness [_] Burning
[_] Itching [_] Bruising [_] Other: _____

How long have you had the problem for? _____

Family Physician: Dr. _____ Phone #: (___) _____-_____
Last Visit: _____
Cardiologist: Dr. _____ Phone #: (___) _____-_____
Last Visit: _____

Are you a Diabetic? YES or NO
If YES for how long? _____

Do you take: Pills / Insulin / Both

Are you in Dialysis? YES or NO
What Physician treats you? Dr. _____ Phone #: (___) _____-_____

Are you on a Blood Thinner? YES or NO
Name of Medication? _____ For how long? _____

Have you had an organ transplant? YES or NO
Type of transplant? _____

ALLERGIES to any medications? YES or NO

MEDICATION	***ALLERGIC REACTION***
Penicillin	
Codeine	
Sulfa	
Iodine / Betadine	
Neosporin	
Local Anesthetic	
Latex Gloves	
Motrin / Ibuprofen / Advil	
Aspirin	
Other:	

ID # _____

DATE: _____/____/____

Patient's Name: _____ D.O.B.: ____/_____/_____

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from:

[_] AIDS / HIV
[_] Alzheimer's
[_] Anxiety
[_] Arthritis Rheumatoid
[_] Artificial Joins
[_] Artificial Valves
[_] Back Problems
[_] Bleeding Disorders
[_] Blood Clots
[_] Blood Pressure (high / low)
[_] Cancer: _____ Active / Remission
[_] Cholesterol (high / low)
[_] Dementia
[_] Depression
[_] Diabetes on Pills / Insulin
[_] Gout
[_] Heart Disease
[_] Hepatitis: A B C
[_] Intestinal Ulcer
[_] Kidney Problems Failure/Disease/Transplant
[_] Liver Disease
[_] Stroke
[_] Thyroid Problems
[_] Tuberculosis
[_] NONE

Other problem(s) **NOT** listed? _____

COMMENTS regarding medical history? _____

Do you have a Pacemaker? YES or NO

Do you have an Implant? YES or NO Where? _____

Do you have a Stent? YES or NO Where? _____

SURGERIES in the past? YES or NO

SURGERY	***DATE***	***SURGERY***	***DATE***

WOMAN ONLY

Are you pregnant? YES or NO

If YES, how many months? _____

Are you currently breastfeeding? YES or NO

SOCIAL HISTORY

Any Special Diet? Yes or No If YES, any restrictions? _____

Tobacco Use? YES or NO Type: _____ Duration: _____ Quit Year: _____

Alcohol Use? YES or NO Frequency: _____ Quit Year: _____

Recreational Drug Use? YES or NO Type and frequency: _____

FAMILY HISTORY

DISEASE	**Family Member(s) That Have It**
Blood Clots	
Cancer	
Diabetes	
Heart Disease High Blood Pressure	
Other:	

ID # _____

DATE: _____

Patient's Name: _____ D.O.B.: ___/____/_____

MEDICATION LIST

Name of Medication	Dosage	How often do you take it?	Reason for taking this Medication?

NEXT PAGE >

ID # _____

Pharmacy Information

Pharmacy Name: _____

Address/ Location of Pharmacy: _____

Pharmacy Phone Number: _____

*If Dr. Lazar prescribes a medication for you; we will send it electronically to your pharmacy of choice within **24 hrs of your appointment**. If you do not receive your prescription please call the office or if the pharmacy states no prescription called in please notify our office. Thank you.*

Leave a Google Review

The highest compliment you can give us is to leave a positive feedback of our practice and services.

Please write a Google Review for Dr. Gabriel Lazar.